

STATE OF NEW HAMPSHIRE  
DEPARTMENT OF HEALTH AND HUMAN SERVICES  
OFFICE OF LEGAL AND REGULATORY SERVICES  
HEALTH FACILITIES ADMINISTRATION  
129 Pleasant Street, Concord, NH 03301  
TDD Access: Relay NH 1-800-735-2964  
Agency Phone: 603-271-9039

**APPLICATION FOR RESIDENTIAL OR HEALTH CARE LICENSE**

LICENSE #: \_\_\_\_\_

EXPIRATION DATE: \_\_\_\_\_

THIS APPLICATION SHALL BE FILLED OUT IN ACCORDANCE WITH RSA 151:4. A SEPARATE APPLICATION MUST BE SUBMITTED FOR EACH LICENSURE CATEGORY. **PLEASE BE SURE TO COMPLETE THE ENTIRE APPLICATION.** IF A SECTION DOES NOT APPLY TO YOUR FACILITY MARK NOT APPLICABLE (N/A). FAILURE TO COMPLETE THE APPLICATION WILL RESULT IN A DELAY IN THE LICENSURE PROCESS. SEND THE COMPLETED FORM TO THE ADDRESS ABOVE.

Check all applicable items:

License renewal:	<input type="checkbox"/>	New administrator:	<input type="checkbox"/>	*New facility:	<input type="checkbox"/>
**New facility name:	<input type="checkbox"/>	*New owner:	<input type="checkbox"/>	*Change in # of beds:	<input type="checkbox"/>
*Change in classification:	<input type="checkbox"/>	*Change in address:	<input type="checkbox"/>	Other (please explain):	<input type="checkbox"/>

\* Requires processing as a new application.

\*\* May require processing as a new application.

LICENSEE: \_\_\_\_\_ TELEPHONE #: (\_\_\_\_) \_\_\_\_\_

NAME OF FACILITY: \_\_\_\_\_ TELEPHONE #: (\_\_\_\_) \_\_\_\_\_

FAX #: (\_\_\_\_) \_\_\_\_\_

STREET ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

MAILING ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

ADMINISTRATOR: \_\_\_\_\_

MEDICAL DIRECTOR (IF APPLICABLE) \_\_\_\_\_

FACILITY E-MAIL ADDRESS \_\_\_\_\_

**IF APPLICABLE:**

NUMBER OF BEDS: \_\_\_\_\_ PRESENTLY LICENSED: \_\_\_\_\_ TOTAL # TO BE LICENSED: \_\_\_\_\_

NUMBER OF HCBC OR STATE PLACED INDIVIDUALS IN HOME \_\_\_\_\_ (804 or 805)

NUMBER OF ESRD STATIONS: \_\_\_\_\_

BRANCH OFFICE

LOCATIONS \_\_\_\_\_

**OWNERSHIP**

a.	Type of ownership:	Association:	<input type="checkbox"/>	Partnership:	<input type="checkbox"/>
		Corporation:	<input type="checkbox"/>	Other (explain) :	<input type="checkbox"/>
		Individual:	<input type="checkbox"/>		

- b. List name and address of each person having an ownership interest (directly or indirectly) of greater than 5% in the facility.
- c. If the licensee is organized as an association or corporation, list the name of the Corporation or association and the name, address and title of each officer.
- d. If the licensee is a partnership, list the name(s) and address(es) of all the partners.

Is this a certified facility? (**Facilities with deem status under RSA 151**) ☐ Yes ☐ No

If you are already a certified facility, is this an increase in services? If yes, please call 1-800-852-3345 ext. 79049

Are you planning on being a certified facility? If yes, please call 1-800-852-3345 ext. 79049

**FEES: (EFFECTIVE JULY 1, 2009)**

Hospitals (General, CAH, Psychiatric, Rehabilitation)	\$25.00 per licensed bed
Nursing Homes	\$25.00 per licensed bed
Residential and Supported Residential Care Homes	\$15.00 PER LICENSED BED (NO CHARGE FOR HCBC OR NH STATE PLACED RESIDENTS)
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Personal Care Providers (822)	Less than 10 clients \$100.00, Ten or More clients \$250.00
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Case Management Agencies	\$150.00

A check or money order (payable to: **STATE OF NEW HAMPSHIRE, TREASURER**), must be attached to this application.

Applications submitted by those facilities exempt under RSA 151:4 are not required to pay the license fee.

**APPLICATION SHALL INCLUDE:**

1. Be submitted at least 120 days prior to expiration of the current license. (**Yearly**)
2. Attach qualifications, including education, experience and copies of all applicable licenses for the administrator and medical director (**if applicable**). (**Yearly**)
3. Include information relative to whether the facility has been granted any exemptions to the rules by the director of the Department of Health and Human Services and/or the State Fire Marshal. (**Yearly**)

4. Floor Plan indicating the location of all rooms, # of beds in each bedroom and fire exits. **(Initial Only-NOT FOR HOME HEALTH OR HOME CARE SERVICE PROVIDERS)**
5. Secretary of State Information. **(Initial Only)**
6. Written local approvals from the health officer, the building official, the zoning officer and the fire chief. For a building under construction, the written approvals required shall be submitted at the time of the application based on the local official's review of the building plans and again upon completion of the construction project. **(Initial Only)**
7. Documentation that the water supply has been tested in accordance with RSA 485 and Env-Dw 702.02 and 704.02 (formerly Env-Ws 313.01 and 314.01). **(Initial Only-NOT FOR HOME HEALTH OR HOME CARE SERVICE PROVIDERS)**
8. Documentation that **every 3 years** the water supply has been tested for bacteria and nitrates and determined to be at acceptable levels, in accordance with Env-Dw 702.02 (formerly Env-Ws 313.01) for bacteria and Env-Dw 704.02 (formerly Env-Ws 314.01) for nitrates. **(NOT FOR HOME HEALTH OR HOME CARE SERVICE PROVIDERS)**
9. A list of all employees who have received criminal background waivers from the Department of Health and Human Services. **(Annual)**
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12. For Durable Medical Equipment Companies submit a copy of your current accreditation.
13. For a facility to be newly licensed on or after July 1, 2016, and to be located within a radius of 15 miles of a critical access hospital, a letter from the CEO of the hospital stating that the proposed new facility will not have a material adverse impact on the essential health care services provided in the service area of the critical access hospital. **(Initial Only for 802, 806, 810, 811, 812, 816, 823 and 824.)**

**FACILITY SERVICE DESCRIPTION:**

The following information will be used to determine which licensure category your facility shall be placed in.

I. Provide a detailed description of the services and programs you wish to provide.

\*II. Describe the facility's health care you wish to provide to residents.

\*III. Identify who will provide the health care listed in II.

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**SIGNATURES:**

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1. the owner if a private facility;
2. 2 officers if a corporation;
3. 2 authorized individuals if an association or partnership;
4. the head of the government department if a government unit.

I affirm that I am familiar with the requirements of RSA 151 and the rules adopted thereunder and that the premises are in full compliance. I understand that providing false information shall be grounds for denial, suspension, or revocation of the license and the imposition of a fine.

DATE: \_\_\_\_\_ SIGNED: \_\_\_\_\_  
(NAME AND TITLE)

DATE: \_\_\_\_\_ SIGNED: \_\_\_\_\_  
(NAME AND TITLE)

**For any facility to be newly licensed on or after July 1, 2016:**

I certify that I have notified the public of the intent to file this application with a description of the facility to be licensed by publishing a notice in a newspaper of general circulation covering the area where the facility is to be located in at least 2 separate issues of the newspaper no less than 10 business days prior to the filing of this application.

DATE: \_\_\_\_\_ SIGNED: \_\_\_\_\_  
(NAME AND TITLE)

DATE: \_\_\_\_\_ SIGNED: \_\_\_\_\_  
(NAME AND TITLE)

**For any facility to be newly licensed on or after July 1, 2016 and is to be located within a radius of 15 miles of a hospital certified as a critical access hospital, pursuant to 42 C.F.R. section 485.610 (b) and (c):**

I certify that the facility is to be located within a radius of 15 miles of a hospital certified as a critical access hospital, pursuant to 42 C.F.R. section 485.610 (b) and (c), and that I have given written notice of the intent to file this application with a description of the facility to be licensed to the chief executive officer of the hospital by registered mail no less than 10 business days prior to the filing of this application.

DATE: \_\_\_\_\_ SIGNED: \_\_\_\_\_  
(NAME AND TITLE)

DATE: \_\_\_\_\_ SIGNED: \_\_\_\_\_  
(NAME AND TITLE)

**BHFA OFFICE USE ONLY**

CHECK NUMBER: \_\_\_\_\_

AMOUNT: \_\_\_\_\_

APPLICATION COMPLETE: \_\_\_\_\_

NOT COMPLETE: \_\_\_\_\_

(Describe in comments)

NEW ☐RENEWAL ☐CHANGE ☐

QUALIFICATIONS OF ADMINISTRATOR	Required <input type="checkbox"/>	Not Required <input type="checkbox"/>	Received <input type="checkbox"/>
COPY OF ADMINISTRATOR LICENSE	Required <input type="checkbox"/>	Not Required <input type="checkbox"/>	Received <input type="checkbox"/>
LIST OF EMPLOYEES WITH WAIVERS	Required <input type="checkbox"/>	Not Required <input type="checkbox"/>	Received <input type="checkbox"/>
WATER TEST (INITIAL OR 3YR)	Required <input type="checkbox"/>	Not Required <input type="checkbox"/>	Received <input type="checkbox"/>
FLOOR PLAN*	Required <input type="checkbox"/>	Not Required <input type="checkbox"/>	Received <input type="checkbox"/>
SECRETARY OF STATE INFORMATION	Required <input type="checkbox"/>	Not Required <input type="checkbox"/>	Received <input type="checkbox"/>
CERTIFICATE OF NEED:	Required <input type="checkbox"/>	Not Required <input type="checkbox"/>	Received <input type="checkbox"/>
LOCAL APPROVAL:	Required <input type="checkbox"/>	Not Required <input type="checkbox"/>	Received <input type="checkbox"/>
LSC INSPECTION:	Required <input type="checkbox"/>	Not Required <input type="checkbox"/>	Received <input type="checkbox"/>
LSC PLAN OF CORRECTION:	Required <input type="checkbox"/>	Not Required <input type="checkbox"/>	Received <input type="checkbox"/>
LICENSURE INSPECTION:	Required <input type="checkbox"/>	Not Required <input type="checkbox"/>	Received <input type="checkbox"/>
PLAN OF CORRECTION:	Required <input type="checkbox"/>	Not Required <input type="checkbox"/>	Received <input type="checkbox"/>
ACCREDITATION FOR DME	Required <input type="checkbox"/>	Not Required <input type="checkbox"/>	Received <input type="checkbox"/>
DMH/DS RISK:	Required <input type="checkbox"/>	Not Required <input type="checkbox"/>	Received <input type="checkbox"/>
CRITICAL ACCESS HOSPITAL LETTER	Required <input type="checkbox"/>	Not Required <input type="checkbox"/>	Received <input type="checkbox"/>

FEDERAL FACILITY (EXEMPT FROM INSPECTION)

YES ☐ NO ☐

LICENSURE CATEGORY:

- |   |   |
|---|---|
| <input type="checkbox"/> 02 Hospitals (CAH, Rehabilitation, Psychiatric and FSER) | <input type="checkbox"/> 14 Community Residence                     |
| <input type="checkbox"/> 03 Nursing Homes   | <input type="checkbox"/> 15 ICF/MR                                  |
| <input type="checkbox"/> 04 Residential Care Home Fac                             | <input type="checkbox"/> 16 Educational Health Services             |
| <input type="checkbox"/> 05 Supported Residential Health Care Fac                 | <input type="checkbox"/> 18 Adult Day Care                          |
| <input type="checkbox"/> 06 Non-Emergency Walk-in Care                            | <input type="checkbox"/> 19 Case Management                         |
| <input type="checkbox"/> 07 Residential Treatment & Rehabilitation Facility       | <input type="checkbox"/> 21 Durable Medical Equipment               |
| <input type="checkbox"/> 09 Home Health Care Provider                             | <input type="checkbox"/> 22 Home Care Service Provider              |
| <input type="checkbox"/> 10 Birthing Center                                       | <input type="checkbox"/> 23 Hospice Care                            |
| <input type="checkbox"/> 11 End Stage Renal Dialysis                              | <input type="checkbox"/> 24 Hospice House                           |
| <input type="checkbox"/> 12 Ambulatory Surgical Center                            | <input type="checkbox"/> 30 Acute Psychiatric Residential Treatment |

REVIEWED BY: \_\_\_\_\_

(NAME &amp; TITLE)

(DATE)

ISSUE ANNUAL LICENSE:

YES \_\_\_\_\_

NO \_\_\_\_\_

LICENSE CERTIFICATE DATES:

FROM \_\_\_\_\_

TO \_\_\_\_\_

NUMBER OF PATIENTS/STATIONS/BEDS \_\_\_\_\_

NOTES:

COMMENTS ON CERTIFICATE:

**STATE OF NEW HAMPSHIRE  
DEPARTMENT OF HEALTH & HUMAN SERVICES  
OFFICE OF OPERATIONS SUPPORT  
HEALTH FACILITIES ADMINISTRATION**

129 Pleasant Street, Concord, New Hampshire 03301-3857

TDD Access: Relay NH 1-800-735-2964

Agency Phone Number: 800-852-3345, Extension 9039 or 603-271-9039

The facility listed below is requesting through the Department of Health and Human Services the following action:

- ☐ Initial Licensing
- ☐ A change in current licensing category
- ☐ Renovation of Existing Building
- ☐ New Construction and/or Addition to Existing Building
- ☐ An increase in current licensed beds / ESRD stations/ or Adult Day Clients

**Please note:** All applicants must have this form filled out by the local officials, even if they do not see clients at their place of business. This is to confirm that the local authorities are aware that a business is operating at the identified location and that the business complies with all local ordinances.

Local authorities please complete and sign each section.

FACILITY/ESTABLISHMENT NAME: \_\_\_\_\_  
STREET ADDRESS: \_\_\_\_\_  
OWNER'S NAME: \_\_\_\_\_  
ADMINISTRATORS NAME: \_\_\_\_\_  
TELEPHONE NUMBER: \_\_\_\_\_  
PROPOSED TYPE OF FACILITY: \_\_\_\_\_

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**HEALTH OFFICER**

I HEREBY CERTIFY THAT \_\_\_\_\_  
COMPLIES WITH ALL APPLICABLE HEALTH, SEWAGE AND WATER REGULATIONS FOR THE CITY/TOWN  
OF \_\_\_\_\_.

I HEREBY CERTIFY THAT \_\_\_\_\_ DOES  
NOT REQUIRE HEALTH, SEWAGE AND WATER APPROVAL OF THIS FACILITY/ESTABLISHMENT.

NUMBER OF BEDS/CLIENTS: \_\_\_\_\_ NUMBER OF ESRD\* STATIONS: \_\_\_\_\_ N/A: \_\_\_\_\_

DATE: \_\_\_\_\_ SIGNATURE: \_\_\_\_\_  
(NAME AND TITLE OF HEALTH OFFICIAL)

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**BUILDING REGULATIONS**

I HEREBY CERTIFY THAT \_\_\_\_\_  
COMPLIES WITH ALL APPLICABLE BUILDING REGULATIONS FOR THE CITY/TOWN OF  
\_\_\_\_\_.

I HEREBY CERTIFY THAT \_\_\_\_\_ DOES  
NOT HAVE LOCAL BUILDING CODES OR REGULATIONS.

NUMBER OF BEDS/CLIENTS: \_\_\_\_\_ NUMBER OF ESRD\* STATIONS: \_\_\_\_\_ N/A: \_\_\_\_\_

DATE: \_\_\_\_\_ SIGNATURE: \_\_\_\_\_  
(NAME AND TITLE OF BUILDING OFFICIAL)

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## ZONING REGULATIONS

I HEREBY CERTIFY THAT \_\_\_\_\_  
COMPLIES WITH ALL APPLICABLE ZONING REGULATIONS FOR THE CITY/TOWN OF \_\_\_\_\_.

I HEREBY CERTIFY THAT \_\_\_\_\_ DOES  
NOT HAVE LOCAL ZONING REGULATIONS.

NUMBER OF BEDS/CLIENTS: \_\_\_\_\_ NUMBER OF ESRD\* STATIONS: \_\_\_\_\_ N/A: \_\_\_\_\_

DATE: \_\_\_\_\_ SIGNATURE: \_\_\_\_\_  
(NAME AND TITLE OF ZONING OFFICIAL)

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## FIRE REGULATIONS

THIS CITY/TOWN USES THE FOLLOWING FIRE CODES: (EXAMPLE NFPA 101 (2003 EDITION)  
CHAPTER \_\_\_\_.)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

☐ I HEREBY CERTIFY THAT \_\_\_\_\_ FD HAS INSPECTED \_\_\_\_\_  
ON \_\_\_\_\_ AND OBSERVED THE FOLLOWING VIOLATIONS:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

☐ I HEREBY CERTIFY THAT \_\_\_\_\_ FD HAS INSPECTED \_\_\_\_\_  
ON \_\_\_\_\_ AND FIND THAT ON THE DATE OF INSPECTION NO VIOLATIONS OF THE FIRE  
CODE ADOPTED BY THE STATE FIRE MARSHAL AND/OR LOCAL MUNICIPAL CODES WERE OBSERVED.

☐ I HEREBY CERTIFY THAT \_\_\_\_\_ FD HAS INSPECTED \_\_\_\_\_  
ON \_\_\_\_\_ AND ALL PREVIOUSLY VIOLATIONS NOTED HAVE BEEN CORRECTED.

NUMBER OF BEDS/CLIENTS: \_\_\_\_\_ NUMBER OF ESRD\* STATIONS: \_\_\_\_\_ N/A: \_\_\_\_\_

DATE: \_\_\_\_\_ SIGNATURE: \_\_\_\_\_  
(FIRE CHIEF OR DESIGNEE)

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\* ESRD = End Stage Renal Dialysis

**COMMENTS:**

10/28/2011

## HOSPITAL AND RESIDENTIAL APPLICATION PROCESS FOR NEW FACILITY, BED INCREASE, CHANGE IN CATEGORY, CHANGE IN ADDRESS

According to RSA 151 :2 (the Residential Care and Health Facilities Law) a facility or agency may not provide any residential or health care services until a valid license is obtained.

Plans must be submitted to Health Facilities Administration and State Fire Marshal's Office for approval prior to commencing work on construction or structural modifications.

1. Obtain application and local approval form.
2. Obtain determination as to whether or not a Certificate of Need is required:

Health Services Planning and Review  
6 Hazen Drive  
Concord, New Hampshire 03301  
(603) 271-4606

The following facilities do not have to obtain this determination:

Residential Care Home	Assisted Living Facility-Supported Residential Care Home
Residential Treatment and Rehabilitation Facility	Accute Psychiatric Rehab., Neuro –RTRF
Hospice House	Laboratory Services
Collecting Station	Home Health Care
Hospice	Birthing Center
End Stage Renal Disease/Dialysis Center	Community Residence
ICF/DD	Educational Health Center
Outpatient Clinic	Health Promotion, Disease Prevention and Screening Clinic
Homemaker	Adult Day Care
Case Management	Tattoo Establishment

UNLESS-you are affiliated with or have an ownership/relationship with any of the following:

Ambulatory Surgical Center  
General Hospital  
Nursing Facility  
Hospice -Supported Residential Care Facility  
Special Hospital -Substance Abuse  
Special Hospital -Psychiatric  
Special Hospital -Rehabilitation  
Freestanding Hospital Emergency Facility

3. Complete all sections of the application.
4. Have local health, building, zoning and fire officers sign approval form. (Zoning officer approval is not necessary for Community Residences.) Date of signatures no more than 30 days prior to submission of application.
5. Determine application fee.

6. Submit #2,3,4 and 5 to Health Facilities Administration, 129 Pleasant Street, Concord NH 03301.
7. Submit qualification, including education, experience and copies of applicable licenses with the application for:
  - a. Administrator.
  - b. Medical Director (if applicable).
8. If applying for a Home Health Care Provider, Case Management, Equipment Management Organization, Homemaker or Home Health Hospice license, submit:
  - a. Copy of the authority to do business in New Hampshire from the Secretary of State.
  - b. Article of Incorporation or Partnership.
  - c. If applying for a Branch office (see He-P 80 1.08(h), submit the information required by He-P 801.02(d)(5).
9. Within 60 days of receipt of the application you will be notified if your application is complete.
  - a. If the application is not complete, you will be informed of what is in error .
  - b. The incomplete application will be returned. When you have corrected the errors or omissions, resubmit the entire application package.
10. Once Health Facilities Administration has received the complete application package two announced inspections will occur .
  - a. Programmatic inspection to determine compliance with RSA 151, He-P 801 and the other appropriate regulations.
  - b. Life Safety Code -to determine compliance with State Fire Code and Physical Environment requirements (not required for Home Health, Hospice, Homemaker, Case Management or Equipment Management Organizations.)
11. Within 120 days of receipt of an acceptable application a decision regarding issuance or denial of your license will be made.
12. If you were in full compliance with all inspection requirements, a license and certificate will be issued.
13. If any deficiencies were identified, your licensing request will be denied.
14. If your licensure request is denied, you will have the right to appeal the decision.
15. If you are found to be providing health care services without a license as required by RSA 141:2, a Cease and Desist order will be issued. Legal action including assessing fines may be taken.

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FAX #: (\_\_\_\_) \_\_\_\_\_

STREET ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

MAILING ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

ADMINISTRATOR: \_\_\_\_\_

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DATE: \_\_\_\_\_ SIGNED: \_\_\_\_\_  
(NAME AND TITLE)

DATE: \_\_\_\_\_ SIGNED: \_\_\_\_\_  
(NAME AND TITLE)

**For any facility to be newly licensed on or after July 1, 2016:**

I certify that I have notified the public of the intent to file this application with a description of the facility to be licensed by publishing a notice in a newspaper of general circulation covering the area where the facility is to be located in at least 2 separate issues of the newspaper no less than 10 business days prior to the filing of this application.

DATE: \_\_\_\_\_ SIGNED: \_\_\_\_\_  
(NAME AND TITLE)

DATE: \_\_\_\_\_ SIGNED: \_\_\_\_\_  
(NAME AND TITLE)

**For any facility to be newly licensed on or after July 1, 2016 and is to be located within a radius of 15 miles of a hospital certified as a critical access hospital, pursuant to 42 C.F.R. section 485.610 (b) and (c):**

I certify that the facility is to be located within a radius of 15 miles of a hospital certified as a critical access hospital, pursuant to 42 C.F.R. section 485.610 (b) and (c), and that I have given written notice of the intent to file this application with a description of the facility to be licensed to the chief executive officer of the hospital by registered mail no less than 10 business days prior to the filing of this application.

DATE: \_\_\_\_\_ SIGNED: \_\_\_\_\_  
(NAME AND TITLE)

DATE: \_\_\_\_\_ SIGNED: \_\_\_\_\_  
(NAME AND TITLE)

**BHFA OFFICE USE ONLY**

CHECK NUMBER: \_\_\_\_\_

AMOUNT: \_\_\_\_\_

APPLICATION COMPLETE: \_\_\_\_\_

NOT COMPLETE: \_\_\_\_\_

(Describe in comments)

NEW ☐RENEWAL ☐CHANGE ☐

QUALIFICATIONS OF ADMINISTRATOR	Required <input type="checkbox"/>	Not Required <input type="checkbox"/>	Received <input type="checkbox"/>
COPY OF ADMINISTRATOR LICENSE	Required <input type="checkbox"/>	Not Required <input type="checkbox"/>	Received <input type="checkbox"/>
LIST OF EMPLOYEES WITH WAIVERS	Required <input type="checkbox"/>	Not Required <input type="checkbox"/>	Received <input type="checkbox"/>
WATER TEST (INITIAL OR 3YR)	Required <input type="checkbox"/>	Not Required <input type="checkbox"/>	Received <input type="checkbox"/>
FLOOR PLAN*	Required <input type="checkbox"/>	Not Required <input type="checkbox"/>	Received <input type="checkbox"/>
SECRETARY OF STATE INFORMATION	Required <input type="checkbox"/>	Not Required <input type="checkbox"/>	Received <input type="checkbox"/>
CERTIFICATE OF NEED:	Required <input type="checkbox"/>	Not Required <input type="checkbox"/>	Received <input type="checkbox"/>
LOCAL APPROVAL:	Required <input type="checkbox"/>	Not Required <input type="checkbox"/>	Received <input type="checkbox"/>
LSC INSPECTION:	Required <input type="checkbox"/>	Not Required <input type="checkbox"/>	Received <input type="checkbox"/>
LSC PLAN OF CORRECTION:	Required <input type="checkbox"/>	Not Required <input type="checkbox"/>	Received <input type="checkbox"/>
LICENSURE INSPECTION:	Required <input type="checkbox"/>	Not Required <input type="checkbox"/>	Received <input type="checkbox"/>
PLAN OF CORRECTION:	Required <input type="checkbox"/>	Not Required <input type="checkbox"/>	Received <input type="checkbox"/>
ACCREDITATION FOR DME	Required <input type="checkbox"/>	Not Required <input type="checkbox"/>	Received <input type="checkbox"/>
DMH/DS RISK:	Required <input type="checkbox"/>	Not Required <input type="checkbox"/>	Received <input type="checkbox"/>
CRITICAL ACCESS HOSPITAL LETTER	Required <input type="checkbox"/>	Not Required <input type="checkbox"/>	Received <input type="checkbox"/>

FEDERAL FACILITY (EXEMPT FROM INSPECTION)

YES ☐NO ☐

LICENSURE CATEGORY:

- |   |   |
|---|---|
| <input type="checkbox"/> 02 Hospitals (CAH, Rehabilitation, Psychiatric and FSER) | <input type="checkbox"/> 14 Community Residence                     |
| <input type="checkbox"/> 03 Nursing Homes   | <input type="checkbox"/> 15 ICF/MR                                  |
| <input type="checkbox"/> 04 Residential Care Home Fac                             | <input type="checkbox"/> 16 Educational Health Services             |
| <input type="checkbox"/> 05 Supported Residential Health Care Fac                 | <input type="checkbox"/> 18 Adult Day Care                          |
| <input type="checkbox"/> 06 Non-Emergency Walk-in Care                            | <input type="checkbox"/> 19 Case Management                         |
| <input type="checkbox"/> 07 Residential Treatment & Rehabilitation Facility       | <input type="checkbox"/> 21 Durable Medical Equipment               |
| <input type="checkbox"/> 09 Home Health Care Provider                             | <input type="checkbox"/> 22 Home Care Service Provider              |
| <input type="checkbox"/> 10 Birthing Center                                       | <input type="checkbox"/> 23 Hospice Care                            |
| <input type="checkbox"/> 11 End Stage Renal Dialysis                              | <input type="checkbox"/> 24 Hospice House                           |
| <input type="checkbox"/> 12 Ambulatory Surgical Center                            | <input type="checkbox"/> 30 Acute Psychiatric Residential Treatment |

REVIEWED BY: \_\_\_\_\_

(NAME &amp; TITLE)

(DATE)

ISSUE ANNUAL LICENSE:

YES \_\_\_\_\_

NO \_\_\_\_\_

LICENSE CERTIFICATE DATES:

FROM \_\_\_\_\_

TO \_\_\_\_\_

NUMBER OF PATIENTS/STATIONS/BEDS \_\_\_\_\_

NOTES:

COMMENTS ON CERTIFICATE: